

SHERIFFDOM OF TAYSIDE CENTRAL AND FIFE AT ALLOA

DETERMINATION

by

SHERIFF O'CARROLL, Esquire, Advocate, Sheriff of Tayside Central and Fife

**following an Inquiry held at Alloa Sheriff Court on 3 October 2013 into the
circumstances of the death of**

WILLIAM SCOTT ELLIS, born 2 June 1959

under the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976

ALLOA, 8 October 2013,

In terms of section 6 of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976, the Sheriff, having considered the evidence and the submissions,

FINDS AND DETERMINES:

(1) In terms of section 6(1)(a) of the Act, that William Scott Ellis, date of birth 2 February 1959, residing latterly at HMP Glenochil by Alloa, died at 10.38 hours on 19 September 2012 at Forth Valley Royal Hospital, Larbert having been admitted there that day.

(2) In terms of section 6(1)(b) of the Act, the cause of death was firstly, cardiomegaly and atherosclerotic coronary artery disease and secondly, hepatic steatosis and type 2 diabetes mellitus.

(3) In terms of section 6(1)(c) of the Act, there were no reasonable precautions whereby the death might have been avoided.

(4) In terms of section 6(1)(d) of the Act, there were no defects in any system of working which contributed to the death.

(5) In terms of section 6(1)(e) of the Act, there were no other facts relevant to the circumstances of the death in respect of which any determination falls to be made.

Makes the following findings in fact:

- (1) On the date of his death, the deceased William Scott Ellis (born 2.6.1959) was serving imprisonment at HMP Glenochil, by Alloa. He was sentenced to lifelong restriction for conspiracy, with a punishment part of four years, imposed at the High Court of Justiciary at Glasgow on 8 July 2009. He was transferred to HMP Glenochil from HMP Barlinnie on 27 January 2011. Crown Production number 2 is the relevant extract conviction and sentence.
- (2) The deceased William Scott Ellis, prisoner at HMP Glenochil, died on 19 September 2012 (aged 53) at 10.38 hours in Forth Valley Royal Hospital, Larbert, having been admitted there that day.
- (3) On that date, Prison Officer John Leitch found the deceased unresponsive in his cell in Abercrombie Hall, Cell 3/10 at HMP Glenochil at 08.25 hours. The deceased had collapsed. Prison medical staff arranged for him to be taken to Forth Valley Royal Hospital, Larbert by ambulance as soon as possible. He was promptly treated and resuscitation measures were attempted, but he died that morning.
- (4) A post mortem examination was carried out on 24 September 2012 by pathologist Dr Graham Whyte. Crown Production number 1 (together with the associated toxicology report prepared by Nitin Seetohul) dated 26 September and 8 October 2012, is a true and accurate account of the post-mortem examination.
- (5) The cause of death of the deceased was: (1) Cardiomegaly and Atherosclerotic Coronary Artery Disease; (2) Hepatic Steatosis, Type 2 Diabetes Mellitus. .
- (6) Cardiomegaly is marked enlargement of the heart. His heart was far larger than what would be expected for a man of his size and weight. As regards Atherosclerotic Coronary Artery Disease: one of the 3 main arteries was severely narrowed by up to 90%. As regards the secondary cause, Type 2 Diabetes Mellitus and Hepatic Steatosis (which is fatty change and marked enlargement of the liver) were significant contributory factors to death.

- (7) The death of the deceased was entirely due to natural causes. He had a number of medical conditions (disease of his heart muscle, coronary arteries and liver) which placed him at high risk of sudden death. These conditions are often only identified post-mortem. His heart disease had been identified and had been previously treated (coronary artery stenting). He was receiving appropriate treatment and medication for his on-going medical conditions. He also had type 2 diabetes, for which he was receiving appropriate medication.
- (8) The combination of his medical conditions posed significant risk to him. They put him at high risk of sudden death due to factors which are difficult to do anything about in medical terms. The most likely mechanism for his death is an abnormality in the electrical conduction system of the heart (cardiac arrhythmia) which often occurs with no preceding warning signs or symptoms.
- (9) There had been no preceding symptoms to alert any prison or medical staff that any other step could have been taken to prevent the death of the deceased.
- (10) It would be reasonable to conclude that normal standards of medical care (whether the patient was in prison or not) would not have been able to prevent the death of Mr Ellis.
- (11) There is no evidence to suggest that the deceased received anything less than appropriate care for his chronic diseases. His conditions appear to have been properly addressed and managed in life.
- (12) There is no evidence to indicate that anything more could have been done for the deceased at the time of his collapse other than the resuscitation measures attempted. The fact that he was a prisoner made no difference to his attempted resuscitation. He was treated as would be expected for any patient.
- (13) The death was intimated to the Registrar by an environmental health officer. Crown Production 3 is the intimation by the Registrar ('form PF').

- (14) The family of Mr Ellis have not intimated any concerns regarding the circumstances of his death. The nearest family member has indicated that the family do not wish to be involved in the fatal accident inquiry process.
- (15) A full investigation was carried out by police into the circumstances of his death. Written statements were obtained by the police from prison staff, Scottish Prison Service medical staff, ambulance staff, paramedics, hospital staff and prison officers.
- (16) There are no reasonable precautions which could have been taken to prevent the death of the deceased William Scott Ellis.

NOTE:

[1] This Fatal Accident Inquiry called before me on 3 October 2013 following sundry procedure.

[2] The procurator fiscal depute, Mr Brian Robertson, appeared for the Crown. Ms Julia McDonald, solicitor, of Anderson Strathern, represented the Scottish Prison Service. There was no appearance by or on behalf of any other person.

[3] I was advised that the fiscal had been in dialogue with members of the family of the deceased. The family did not wish to be present or represented at the Inquiry.

Legal Framework

[4] The Fatal Accident and Sudden Deaths Inquiry (Scotland) Act 1976 (the Act) Section 1(1)(a)(ii) provides that a Public Inquiry should be held into the death of any person held in legal custody. The purpose of the Inquiry is for the sheriff to make a determination setting out the following circumstances of the death so far as they have been established to his satisfaction :

- (a) where and when the death and any accident resulting in the death took place;
- (b) the cause or causes of such death and any accident resulting in the death;
- (c) the reasonable precautions, if any, whereby the death and any accident resulting in the death may have been avoided;

- (d) the defect, if any, in the system of working which contributed to the death or any accident resulting in the death;
- (e) any other facts which are relevant to the circumstances of the death (all in terms of Section 6(1) of the Act).

[5] The Court proceeds on the basis of the evidence placed before it and although described as an Inquiry, the sheriff's powers do not go beyond making a determination in relation to the circumstances established to his satisfaction by evidence following upon investigation by the procurator fiscal and any other party if so advised.

[6] The evidence before the enquiry comprised the following. The Crown lodged an affidavit of Dr Graham Whyte dated 8 September 2013. He is a pathologist employed by the University of Dundee. The affidavit speaks to: the post-mortem of the deceased which he carried out on 24 September 2012; his report regarding that autopsy; his opinion as to the cause of death and his opinion regarding the circumstances surrounding the death. Also lodged in evidence was Dr Graham Whyte's autopsy report which was labeled as Crown Production 1 (together with the associated toxicology report prepared by Nitin Seetohul). The Crown also lodged the extract conviction and sentence pertaining to the deceased as Crown Production 2 and the report of death to the Procurator Fiscal as Crown Production 3.

[7] The two represented parties entered into a joint minute which was lodged in process. In that joint minute, the parties adopted the findings of Dr Whyte and agreed a number of other matters concerning the circumstances surrounding the death of the deceased.

[8] I was assured by the parties' representatives that the statements obtained during the full investigation carried out following the death of the deceased, which they had each seen and read, do not give rise to any doubt as to the accuracy of the findings and opinion of Dr Whyte. Those statements were not lodged or otherwise made available to the Inquiry by the Crown. It was on this basis that the parties entered into the joint minute and they chose not to lead any evidence other than the affidavit of Dr Whyte.

[9] It is the duty of the Procurator Fiscal to adduce evidence with regard to the circumstances of death: section 4(1) of the 1977 Act. It is competent to lead evidence by way of affidavit in lieu of oral evidence: Rule 10 of the Fatal Accidents and Sudden Deaths Inquiry Procedure (Scotland) Rules 1977.

[9] I was satisfied on the basis of the evidence, the Crown productions and the joint minute, and on the assurances given to me by the parties' representatives, that I was able to make the determination that I have. The findings in fact and my Determination are based on that material.

[10] This is my written Determination as required by section 11 of the 1977 Act. In terms of section 11(3) of the Act, I consider that it is not reasonable to fix an adjourned sitting of the enquiry for the sole purpose of reading out this determination. A copy has been sent to the parties and will be placed on the SCS website.

[11] Finally, I wish to offer my condolences to the members of the deceased's family.

Sheriff O'Carroll, Advocate
Sheriff of Tayside Central and Fife
8 October 2013